

0307 AUDIT OF AUDITS IN AN ORTHOPAEDIC UNIVERSITY TEACHING HOSPITAL: A EIGHT AND HALF YEAR EXPERIENCE

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Background: Audits are a systematic examination of current practice to assess how well an institution or a practitioner is performing against set standards. It is a fundamental pillar of clinical governance.

Objectives: To assess the quality and prevalence of orthopaedic audits undertaken in a teaching hospital within an 8 and half years period.

Methods: Between February 2002 and August 2010 all orthopaedic audits registered with the audit department, were eligible for this review. Each audit was assessed against the Department of Health definition of audit. Review of audit proforma, reason for audit, if recommendations were suggested/implemented and completion of audit loop, were documented and analysed in a computerized database.

Results: 100 audits within an eight and half year period (average 0.98 audits per month) were reviewed. 60% were true audits which had guidelines, majority of these were presented in Clinical Governance meeting. 40% had resulted in changes being implemented and 17 % completed the audit cycle.

Conclusion: Clinical audit is not common practice. It should not just be a tick box exercise for junior doctors. An understanding of clinical governance and audit is of paramount importance for all doctors. Clinical audit will not succeed until such deficiencies are rectified.

0309 OUTCOME ANALYSIS OF MAJOR LOWER LIMB AMPUTATIONS IN A HIGH VOLUME TEACHING HOSPITAL IN THE UNITED KINGDOM

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Objective: Despite aggressive emphasis on revascularization for limb salvage, lower limb amputation is still a commonly performed surgery. Objective of our study was to gain an understanding of patient demographics, revascularization history, comorbidity, indications, morbidity and mortality rates in a high volume institution in the United Kingdom.

Method: A retrospective analysis of patients undergoing lower limb amputation between 2007 to 2010 was undertaken.

Results: 108 patients underwent amputation. Overall 30 day mortality was 8 % with AKA performing worse 12.5%vs5.4% ($p<0.001$). 43 were AKA and 64 BKA. The commonest indication was end stage ischaemia 53%. 5 were converted from BKA to AKA. Previous revascularisation was done in 74 with angioplasty/stent been the highest. Previous Fem-pop was done in 28%. 33 patients had buegers flap with 22 having skew flaps and 4 with through knee amputations. Amputation site complications occurred in 35%. 26% needed a further procedure for failure of the wound to heal. 67 amputations were performed by trainee surgeons. 72% were alive while 25% died in the series.

Conclusions: Significant proportion of amputations continues to be done by trainees. Conversion from BKA to AKA is minimal. Significant number of AKA continues to occur despite the poor rehabilitation outcome in this group.

0311 ARE NATIONAL GUIDELINES ON CONSENT FOR BLOOD TRANSFUSION BEING FOLLOWED? A PATIENT SURVEY

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Aims: Complications from the transfusion of blood products are uncommon but can be life threatening. UK Transfusion Service national guidelines recommend that there should be a documented discussion with the patient about the proposed treatment. They should also have access to literature documenting the risks, benefits and alternatives. We aimed to explore how well-informed patients receiving blood transfusions in our surgical department were.

Methods: Patients receiving a blood transfusion during November 2010 were invited to complete a questionnaire after the transfusion was complete. Patients were excluded if they received the transfusion as an emergency or during an operation.

Results: 36 patients received 40 transfusions during the study period, 32 were fit to answer a questionnaire. 71% understood why they needed the transfusion and 81% had given consent (44% by a nurse). This was only documented in the notes in 2 cases. 28% were explained the risks, although no-one was aware of alternatives. 31% received literature about receiving a transfusion.

Conclusions: Our patients seem poorly informed of the risks of receiving transfusions. This could have significant medico-legal ramifications in the result of an adverse event. Good literature is available and doctors should be educated to use this to inform patients.

0312 IS A FLEXIBLE SIGMOIDOSCOPY NECESSARY IN THE EVENT OF A NORMAL CT COLONOSCOPY?

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Aims: To determine whether flexible sigmoidoscopy is required in the event of a normal CT colonoscopy.

Investigation of the large bowel for suspected colorectal cancer (CRC) is traditionally performed with either colonoscopy or flexible sigmoidoscopy and barium enema. CT colonoscopy (CT Colon) has revolutionised the diagnosis of CRC and many studies have shown a comparative sensitivity with colonoscopy.

Methods: We prospectively collected the data of 220 consecutive patients over a six month period with a suspected diagnosis of CRC. We compared CT Colonoscopy findings with the flexible sigmoidoscopy reports.

Results: 110 patients were identified as having a flexible sigmoidoscopy and CT Colon. 78% had a matching CT colon and flexible sigmoidoscopy report. 88% of patients had a working diagnosis from CT colon alone. 12% had suspected pathology on flexible sigmoidoscopy which was not picked up by CT colon. After examining histology from flexible sigmoidoscopy we found all specimens were under 1cm and revealed low grade dysplasia at worst.

Conclusions: The above findings question the need for a flexible sigmoidoscopy in the event of a normal CT colonoscopy. We conclude that when investigating for suspected CRC flexible sigmoidoscopy is perhaps an unnecessary investigation if CT colonoscopy is performed.

0313 THE JOINT ADVISORY GROUP ON GASTROINTESTINAL ENDOSCOPY NATIONAL SURVEY OF ENDOSCOPY TRAINING AMONGST UK-BASED HIGHER SURGICAL TRAINEES

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Background: This survey set out to evaluate the state of gastrointestinal endoscopy training amongst UK-based surgical trainees on behalf of the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

Methods: A national survey of endoscopy training was undertaken using a web-based survey tool with a £500 incentive (JAG). UK-based trainees were contacted via their programme director and speciality organisation.

Results: 233 trainees responded from all UK training regions. 55% were senior (\geq year 4). Stated interests were coloproctology (47%), oesophago-gastric/bariatric (22%), hepatobiliary/pancreatic (10%) and general surgery (5%). 91% of trainees were training/planning to train in endoscopy, 62% of whom had registered with JAG. 13 trainees had JAG accreditation in diagnostic upper GI endoscopy and 8 in colonoscopy. No trainees had accreditation in ERCP. There were high rates of dissatisfaction with endoscopy training nationally. Two thirds of trainees had no scheduled training lists. Conflicting elective/emergency commitments, competition and absence of training lists were the most common reasons for a failure to access endoscopy training.

Conclusions: Less than 10% of the UK-based surgical trainees have JAG accreditation for GI endoscopy. There is a need to address the deficiencies in endoscopy training on a local and national level.